

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH:

County Garrett
 City or town Rural- Kitzmiller
 (If outside city or town limits, write RURAL and give nearest town)
4 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peerless- 2 Miles West of Kitzmiller

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Mineral
 City or town Rural- Keyser
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R.#2, Reeses Mill

(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Robert Hull Anderson

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Mary (Mayberry) Anderson

6.(c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1962

8. AGE:

Years 85Months 6Days 27

If less than one day

hrs. min.

9. Birthplace New Castle, Penna.

(Town, county, and state)

10. Usual occupation Retired Farmer11. Industry or business Don't Know

FATHER

12. Name

13. Birthplace Don't Know

MOTHER

14. Maiden name

15. Birthplace Don't Know16. Informant Walter AndersonAddress Kitzmiller, Md.17. Burial May 16, 1948

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory Hartmansville CemeteryLocation Hartmansville, Mineral Co., W. Va.

18. Funeral director

Otha F. SharplessAddress Blaine, W. Va.19. May 15, 1948 AWB
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1948 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

examined after death 19

and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

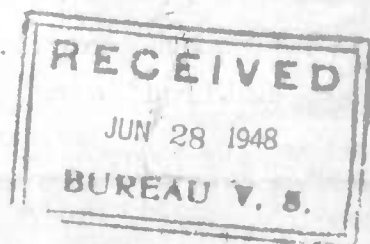
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE E. J. Brummett M. D. or otherAddress Carlan Dr. Date signed 5/14/48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05040

166

1. PLACE OF DEATH:

County... Garrett
 City or town... Loch Lynn, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Maryland life time.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Garrett
 City or town... Loch Lynn, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Dorsey L. Ashby.

3. (b) Social Security Number

None.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married.

6. (b) Name of husband or wife

Emma F. Ashby.

7. Birth date of deceased (mo., day, yr.)

July 21st, 1855.

6. (c) If alive, give age

82 years

8. AGE:

Years

Months

Days

If less than one day

921020

hrs.

min.

9. Birthplace

Garrett County.

(Town, county, and state)

10. Usual occupation

Retired Farmer.

11. Industry or business

MOTHER FATHER

12. Name

William W. Ashby.

13. Birthplace

Garrett County.

14. Maiden name

Helen Thayer.

15. Birthplace

New York State.

16. Informant

Mrs. Harry Nicholson.

Address

Loch Lynn, Md.

17.

Burial

Date thereof

May 12th/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Ashby Cemetery.

Location

Near Crellin, Maryland.

18. Funeral director

Emory D. Bolden.

Address

Oakland, Md.

19.

May 13/48

19.

Julia A. Tabor

Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH... may 10th 1948 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 101948to May 10th1948and that I last saw him alive on 5-9-48

19

Immediate cause of death

Heart Failure

DURATION

2 daysDue to Influenza7 weeks

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

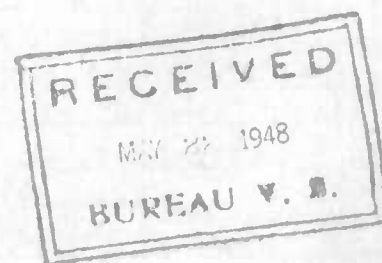
23. SIGNATURE

Address

Oakland, Maryland

Date signed

5/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Swanton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Swanton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Bradley Thomas Johnston Bray

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Margaret Jane Campbell7. Birth date of deceased (mo., day, yr.) July 20, 1859

6.(c) If alive, give age years

8. AGE: Years 88 Months 10 Days 7 If less than one day
..... hrs. min.8. Birthplace Walnut Bottom, Garrett Co., Md.
(Town, county, and state)10. Usual occupation Retired-Farmer & Miner

11. Industry or business

FATHER 12. Name John William Bray
13. Birthplace Mt. Zion, Garrett Co., Md.MOTHER 14. Maiden name Adelia Ann Paugh
15. Birthplace Mt. Zion, Garrett Co., Md.16. Informant Mrs. Teressa Friend
Address R#3, Swanton, Md.17. Burial Date thereof May 30, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)
George CemeteryCemetery or crematory
Swanton, Md.Location Otha F. Sharpless18. Funeral director Blaine, W.Va.Address
May 30, 1948 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 27 48 1:25 A.
19....., at..... M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27th 48
19....., to....., at.....and that I last saw him in May 19th 48
19....., alive on.....Immediate cause of death Cerebral Hemorrhage
DURATION 8 daysDue to High Blood pressure and Nephritis 1 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward E. Ballan M. D. or otherAddress Oakland Maryland Date signed 5-28-48

1948
1936

12

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JUN 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05042 166

1. PLACE OF DEATH:

County..... Garrett
 City or town..... Bloomington Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years
 Hospital, institution, or street address where death occurred:
no Hospital
Near Bloomington Md Rural
 How long in hospital or institution.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Garrett
 City or town..... Near Bloomington Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... no

3. (a) FULL NAME

Lucian L Bucklew.3. (b) Social Security Number
no

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Widower
 6.(b) Name of husband or wife..... no wife
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... April 1st 1859
 8. AGE: Years..... 89 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... West Virginia
 (Town, county, and state)
 10. Usual occupation..... Farmer,
 11. Industry or business.....

FATHER 12. Name..... John W. Bucklew.
 13. Birthplace..... Unknown.
 MOTHER 14. Maiden name..... Lavinia Markley.
 15. Birthplace..... Unknown.

16. Informant..... Mrs. Nellie Wise.
 Address..... Bloomington, Md.
 17. Burial Date thereof..... May 27th/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Oakland, Cemetery.
 Location..... Oakland, Md.

18. Funeral director..... Ernest P. Bolden
 Address..... Oakland, Md.
 19. 5/27/48 48 Julius A Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

am20. DATE OF DEATH..... May 26 1948 at 3.08 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 15 1948 to May 26 1948
 and that I last saw him alive on May 24 1948

Immediate cause of death.....
Myocardial Degeneration, DURATION 1yr

Due to..... Arterio Sclerosis 5yrs

Due to.....

Other conditions..... Duodenal Ulcer. 2yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury..... Injured at work?

23. SIGNATURE.....
 M. D. or other

Address..... Piedmont W Va Date signed..... 5/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 9 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05043 166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
48 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -----
 (If rural, give LOCATION)
 2.(a) If veteran, name war -----

3. (a) FULL NAME

Katherine O. Chance

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

B.(b) Name of husband or wife James E. Chance

7. Birth date of deceased (mo., day, yr.) January 30, 1862 6.(c) If alive, give age ----- years

8. AGE: Years 85 Months 3 Days 16 If less than one day ----- hrs. ----- min.

9. Birthplace Queen Ann County, Md.
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own Home

12. Name Thomas Vansant

13. Birthplace Unknown

14. Maiden name Eliza Covey

15. Birthplace Unknown

16. Informant Mrs. Louise Selby
 Address Oakland, Maryland.

17. Burial 5/19/48
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Oakland Cemetery
 Location Oakland, Maryland.

18. Funeral director Nesbitt P. Reighton
 Address Oakland, Maryland.

19. 5/19/48 19 48 Julius A. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 19 48, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.4.5 to May 16 19 48
 and that I last saw him alive on May 15 19 48

Immediate cause of death Chronic Hypertension DURATION 10 yrs.

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Carl Baumgartner M.D.

Address Oakland Md Date signed 5/19/48

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JUN 9 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05044

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One Month
 Hospital, institution, or street address where death occurred:
Kiser Nursing Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 204 Seymour St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

David W. Chaney

3. (b) Social Security Number

none

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Fannie Chaney
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 5, 1859
 8. AGE: Years 88 Months 10 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Springfield-Hampshire, W.VA.
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business

FATHER 12. Name Unknown
 13. Birthplace
 MOTHER 14. Maiden name Unknown
 15. Birthplace

16. Informant Mrs. Leonard Adams
 Address Piedmont, W.VA.
 17. Burial Date thereof May, 19, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Bier Cemetery
 Location Rawlings, Md.

18. Funeral director Ellsworth S. Boal
 Address Westernport, Md.

19. May 19, 19 48 Julia A. Rowan
 (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May, 16th, 19 48 at 1:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April, 18, 19 48 to May, 16, 19 48
 and that I last saw him alive on May, 13, 1948

Immediate cause of death
Arteriosclerosis
Senility

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE Thomas J. Leahy M.D.
 _____ M.D. or other
Oakland, Maryland. Date signed May 16/1948

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JUN 9 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett
 City or town Rural - Grantsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Catherine Durst

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Michael Wm Durst7. Birth date of deceased (mo., day, yr.) June. 24, 1854

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

931026

..... hrs.

..... min.

9. Birthplace Rural - Grantsville (Garrett) Md.
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

FATHER
MOTHER

12. Name

Jacob Spiker

13. Birthplace

Rural - Grantsville, Md.

14. Maiden name

Barbara Durst

15. Birthplace

Not Known16. Informant Louie Livengood

Address

Rural - Grantsville, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

5-23-1948

(month) (day) (year)

Cemetery or crematory

Grantsville

Location

Grantsville, Md.

18. Funeral director

Wm Winterberg

Address

Grantsville, Md.

19.

May 22
(Date rec'd by registrar)

19

48Ethel Broadwater

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Rural - Grantsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name War

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1948, at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1948, to May 21 1948and that I last saw her alive on May 10 1948

Immediate cause of death

Ischemic W. myocardial infarction

DURATION

3 yrs

Due to

Due to

Other conditions

Heart tely

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

N. B. Davis, M.D.

M. D. or other

Address

Grantsville, Md.

Date signed

May 24 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05046

Reg. Dist. No. 162

1. PLACE OF DEATH: County..... <u>Garett</u> City or town..... <u>Grantsville Md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>25 Years</u> Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md</u> County..... <u>Garett</u> City or town..... <u>Grantsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3.(a) FULL NAME <u>Cora Belle Frickey</u>				3.(b) Social Security Number <u>None</u>			
4. Sex <u>F</u> 5. Color or race <u>W</u> 6.(a) Single, married, widowed, or divorced <u>Married</u>				MEDICAL CERTIFICATION			
6.(b) Name of husband or wife <u>Noyah Frickey</u> 6.(c) If alive, give age <u>53</u> years				20. DATE OF DEATH <u>May 4</u> 19 <u>48</u> , at <u>11:00 a.m.</u> M			
7. Birth date of deceased (mo., day, yr.) <u>July -6-1895</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 1</u> 19 <u>46</u> , to <u>May 4</u> 19 <u>48</u> and that I last saw him/her alive on <u>May 2</u> 19 <u>48</u> Immediate cause of death <u>Myocarditis chronic</u> DURATION.....			
8. AGE: Years <u>53</u> Months <u>9</u> Days <u>4</u> If less than one day..... hrs. min.				Due to..... Due to..... Other conditions..... <u>Myocarditis chronic</u> 10 yr (Include pregnancy within 3 months of death)			
9. Birthplace <u>Near Jennings -Garett-Co-Md</u> (Town, county, and state)				Major findings of operations..... Date of op.....			
10. Usual occupation <u>House Work</u>				Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
11. Industry or business				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
12. Name <u>Wilson Bittinger</u> 13. Birthplace <u>Near Jennings Md</u> 14. Maiden name <u>Mary Hetrick</u> 15. Birthplace <u>Near Jennings</u>				23. SIGNATURE <u>M. R. Davis M.D.</u> Address..... <u>Grantsville Md</u> Date signed <u>May 7/48</u>			
16. Informant <u>Kermit Bittinger</u> Address..... <u>Grantsville Md</u>				19 <u>May 5</u> 19 <u>48</u> <u>Ethel Broadwater</u> (Date rec'd by registrar) Registrar			
17. Burial <u>Maple Grove</u> (Burial, cremation, or removal. Which?) Date thereof..... <u>5-8-1948</u> (month) (day) (year) Cemetery or crematory..... Location..... <u>Near Grantsville Md</u>				18. Funeral director <u>Wm. Winterberg</u> Address..... <u>Grantsville Md</u>			

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MAY 10 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05047

166

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland, Rt.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland, Md. Rt.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elijah J. Friend.

3. (b) Social Security Number

213-18-2946

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.

6.(b) Name of husband or wife Goldie Friend.
 6.(c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) May 13th, 1872.

8. AGE: Years 75 Months 11 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Sang Run, Md.
 (Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

12. Name John Frederick Friend.
 13. Birthplace Sang Run, Md.
 14. Maiden name Rachel Ross Friend.
 15. Birthplace Sang Run, Md.

16. Informant Mrs., Henry Campbell.
 Address Oakland, Md.

17. Burial Date thereof May 9th/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oakland Cemetery.
 Location Oakland, Md.

18. Funeral director Emory D. Bolden,
 Address Oakland, Md.

19. May 9th 48 19 48 Julius A. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 48 at 5⁰⁰ A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Spanned after death 19 48
 and that I last saw him alive on 19 48

Immediate cause of death Suicide by firearm
with Remington pump &
action 2 shot

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 5/6/48Where did injury occur? near Oakland Garrett Md
 (City or town) (County) (State)injured at home, farm, industry, public place (where?) homeMeans of injury Shot with 22-20 injured at work? noSignature E. J. Rowan M.D. examiner
 M. D. or other23. SIGNATURE Oakland Md Date signed 5/8/48

Address _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 168

1. PLACE OF DEATH: County <u>Garrett</u> City or town <u>R. D. 2 Frostburg</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Garrett</u> City or town <u>R. D. 2 Frostburg</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Noah Sylvester McKeuzie</u>				3. (b) Social Security Number <u>none</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Inez M. McKeuzie</u>				6. (c) If alive, give age <u>62</u> years			
7. Birth date of deceased (mo., day, yr.) <u>September 4, 1865</u>				20. DATE OF DEATH <u>May 29</u> 19 <u>48</u> at <u>5:30</u> P. M.			
8. AGE: Years <u>82</u> Months <u>8</u> Days <u>25</u> If less than one day _____ hrs. _____ min.				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Aug. 1</u> 19 <u>47</u> to <u>May 29</u> 19 <u>48</u> and that I last saw him alive on <u>May 1</u> 19 <u>48</u>			
9. Birthplace <u>Awilton, Garrett, Md.</u> (Town, county, and state)				Immediate cause of death <u>Coronary thrombosis</u>			
10. Usual occupation <u>retired</u>				Due to <u>Coronary Sclerosis</u>			
11. Industry or business <u>farmer</u>				Due to <u>Coronary Sclerosis</u>			
12. Name <u>unknown</u>				Other conditions			
13. Birthplace				(Include pregnancy within 3 months of death)			
14. Maiden name <u>unknown</u>				Major findings of operations			
15. Birthplace				Date of op.			
16. Informant <u>Norman McKeuzie</u>				Autopsy results			
Address <u>Frostburg, Md.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>McKeuzie cemetery</u> Date thereof <u>June 1, 1948</u> (Burial, cremation, or removal. With day) (month) (day) (year)				22. VIOLENCE: If death was due to external causes, fill in the following:			
Cemetery or crematory <u>Garrett County, Md.</u>				Accident, suicide, or homicide. Date of			
Location <u>J. R. District</u>				Where did injury occur? (City or town) (County) (State)			
18. Funeral director <u>Frostburg, Md.</u>				Injured at home, farm, industry, public place (where?)			
Address				Means of injury Injured at work?			
19. May 30 - 19 48 <u>McKeuzie Michael</u> (Date signed by registrar) Registrar				23. SIGNATURE <u>W. M. Kane MD</u> M. D. or other			
Address <u>Frostburg Md.</u>				Date signed <u>5-30-48</u>			

RECEIVED

JUN 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05049

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett CountyCity or town Granville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 minutes

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Katie Alice Troyer

3. (b) Social Security Number

4. Sex

Daughter

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.)

Dec. 1947

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5 20 hrs. min.

9. Birthplace

Plain City

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

Dan D. Troyer

13. Birthplace

Plain City Ohio

14. Maiden name

Edna (Schlack) Troyer

15. Birthplace

Plain City

16. Informant

Dan D. Troyer

Address

Plain City Ohio R. 2

17. (Burial, cremation, or removal. Which?)

BurialDate thereof May 17, 1948
(month) (day) (year)

Cemetery or crematory

Amish cemetery

Location

2 1/2 mile South East of Plain City

18. Funeral director

Mon Wintering

Address

Granville Ohio

19. (Date rec'd by registrar)

May 15 1948 Ethel Broadwater

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Ohio

County

Madison County

City or town

Plain City R. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15 1948

at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1948 to May 15 1948

and that I last saw

her alive on May 15 1948

Immediate cause of death

Bronchopneumonia

DURATION

Due to.....

Due to.....

Other conditions

malnutritionRickets

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Examined

Injured at work?

23. SIGNATURE

Benedict Skutarcic M.D.

M. D. or other

Address

R 3 Cumberland, MdDate signed 5/15/48

RECEIVED

MAY - 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr
 Hospital, institution, or street address where death occurred:
Keiser Nursing Home
 How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1012 Keel Court
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Emma Gertrude Twigg
 4. Sex female 5. Color or race white 6.(a) Single, married, widowed or divorced Married Widowed

6.(b) Name of husband or wife Henry W. Twigg7. Birth date of deceased (mo., day, yr.) October 14, 1873

8. AGE: Years 74 Months 6 Days 18 If less than one day hrs. min.

9. Birthplace Lewisstown, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name FATHER Thompson13. Birthplace ?14. Maiden name ?15. Birthplace ?16. Informant Edgar TwiggAddress Ft. Ashby, W. Va.

17. Burial Date thereof May 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest CemeteryLocation Cumbarland, Md.18. Funeral director John J. HefnerAddress Cumbarland, Md.

19. May 4 1948 Julius Rowan
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to May 2nd 1948
 and that I last saw him or alive on May 1st 1948

Immediate cause of death Cerebral Hemorrhage
 DURATION 24 hour

Due to Acute Nephritis 1 yrDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date ofWhere did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Injured at work?Means of injury Injured at work?23. SIGNATURE Oakland, Maryland M. D. or other 5-3-48Address Oakland, Maryland Date signed 5-3-48

RECEIVED

JUN 9 1948

BUREAU V. S.

Mailed Certificate back
to informant to obtain
family record, but he
did not seem to be
able to obtain any.

Mr. Mis. addressed the
envelope instead of
to Oakland Maryland
to Oakland Penn.
Mr. Sollars. was sick and
not really able to sign
his name

FIRE AND ALLIED LINES

INSURANCE COMPANY

CITY of NEW YORK

Insure with

note

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95C

05051
766

Reg. Dist. No.

1. PLACE OF DEATH: **Garrett**
County **Crellin**
City or town **1 week**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State **Maryland** County **Garrett**
City or town **Oakland**
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)
2.(a) If veteran, name war -----

3. (a) FULL NAME
Richard Marshall Upole

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **married**

6. (b) Name of husband or wife **Fannie R. Schaeffer Upole**

6. (c) If alive, give age **71** years

7. Birth date of deceased (mo., day, yr.) **October 14, 1874**

8. AGE: Years **73** Months **6** Days **28** If less than one day
----- hrs. ----- min.

9. Birthplace **Garrett Co., Md.**
(Town, county, and state)
Farmer

10. Usual occupation **Own Farm**

11. Industry or business **William M. Upole**

12. Name **Elizabeth Tasker**

13. Birthplace **Garrett Co., Md.**

14. Maiden name **Garrett Co., Md.**

15. Birthplace **Mrs. R. M. Upole**

16. Informant **Oakland, Md.**

Address **Burial**

17. Date thereof **May 14, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Schaeffer Home Cemetery**

Location **1 Mile South Mt. Storm, W. Va.**

18. Funeral director **Herbert C. Reighton**

Address **Oakland, Maryland.**

19. **5/14/48** 19 **48** **Julia A. Rowan**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 12, 1948 12:34 P.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 1st 1947** to **May 12 1948**
and that I last saw him alive on **May 5th 1948**

Immediate cause of death **Heart Disease**

DURATION

Due to -----

Due to -----

Other conditions **Mental weakness**

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

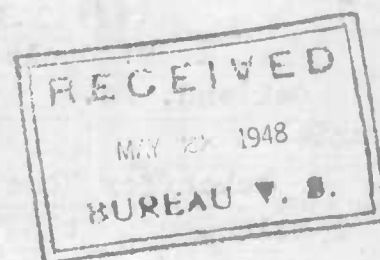
Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work?

23. SIGNATURE **Thompson M.D.** M.D. or other

Address **Oakland** Date signed **May 14/48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131a 05052 162

1. PLACE OF DEATH:

County Garett
 City or town Rural Near Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Four Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garett
 City or town Rural Near Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Henry Warne
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

213-18-2656

6.(b) Name of husband or wife Matilda Warne
 7. Birth date of deceased (mo., day, yr.) July -3-1887
 6.(c) If alive, give age _____ years

8. AGE: Years 60 Months 10 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Ocean Alleghany Co Md
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Daniel Warne
 13. Birthplace Frostburg Md

14. Maiden name Margaret Humbertson
 15. Birthplace Confluence Pa

16. Informant Mrs Matilda Warne
 Address Grantsville Md

17. Burial Date thereof May -13-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Zion
7-M-E-Of Grantsville On-R-40
 Location

18. Funeral director Wm Winterberg
 Address Grantsville Md

19. May 11 1948 Ethel Broadwater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 48 930 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to May 10 19 48
 and that I last saw him alive on May 10 19 48

Immediate cause of death Chronic Intestinal Hepatitis DURATION 2 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. R. Davis M.D. M. D. or other _____

Address Charterville Md Date signed May 11 1948

NOITAR

NOITAR

